STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT GARDEN PLAZA	8614 W 10TH ST INDIANAPOLIS, IN 46234

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R000000	This visit was for a State Licensure Survey. The following residential findings were cited in accordance with 410 IAC 16.2-5. Dates of Survey: October 3 and 4, 2013. Facility number: 005616 Provider number: 005616 AIM number: N/A Survey Team: Laura Brashear, RN, TC Teresa Buske, RN Karen Hartman, RN Census bed type: Residential: 87 Total: 87 Census Payor type: Other: 87 Total: 87 Sample: 11 These state findings are cited in accordance with 410 IAC 16.2. Quality review completed on	R000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	10/10/2013 by Brenda Marshall Nunan, RN			

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R000217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review, and interview, the facility failed to provide services according to current physician order frequency for 1 of 1 residents reviewed receiving dialysis. (Resident #38) Finding includes:	R000217	R217: Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law. With Respect to the	11/01/2013

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	Upon review of Resident #38's clinical record on 10/4/13 at 1 p.m., a current physician's order dated, 4/21/13, of "Check B/P [blood pressure] on non-dialysis days and fax monthly to Dr.___[physician specific name and phone number]." Upon review of the monthly treatment records for May 2013, June 2013, July 213, August 2013, September 2013, and October 2013, blood pressure results for non-dialysis days were incomplete according to the physician's order frequency. Documentation was lacking. The May 2013 treatment record lacked documentation to indicate blood pressure monitoring for 2 of 17 non-dialysis days (5/7/13, and 5/19/13.) The July 2013 treatment record lacked documentation of completion of blood pressures on non-dialysis days for 7 of 17 days (7/13, 7/14, 7/18, 7/20, 7/21, 7/27, and 7/28). The August 2013 treatment record lacked documentation of completion of blood pressures on non-dialysis days for 18 of 18 days (8/1, 8/3, 8/4, 8/6, 8/8, 8/10, 8/11, 8/13, 8/15, 8/17,		Specific Residents Cited: Resident # 38 did not experience a negative outcome. Physician follow up was conducted during the survey for order clarification including Blood Pressure results communication. Physician ordered blood pressures shall be recorded on the Medication Administration Record. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: A review of the Physician Orders and Medication Management Policies were completed by the Resident Care Director and Administrator. An audit of resident physician orders was completed to ensure compliance. The Resident Care Director will review New and Change Physician Orders. Physician ordered blood pressures shall be recorded on the Medication Administration Record. The 24-hour report and resident clinical record will indicate physician communication of ordered Blood Pressures. With Respect to What Systemic Measures have been put in place to Address the Stated Concern: In-service training was provided for Licensed Nurses and Qualified Medical Assistants on Follow Physician Orders and MAR documentation compliance expectations. With Respect to How the Plan of Corrective Measures will be monitored The	

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	8/18, 8/20, 8/22, 8/24, 8/25, 8/27, 8/29, and 8/31). The only blood pressures recorded were on 8/5/13, and 8/12/13. The September 2013 treatment record lacked documentation of completion of blood pressures on non-dialysis days for 2 of 17 days (9/3, and 9/17). Upon interview of Qualified Medication Aide (QMA) #1 on 10/4/13 at 1:50 p.m., the QMA indicated Resident #38 had hemodialysis on Monday, Wednesday, and Friday. The QMA stated she did not remember faxing the recorded blood pressures to the physician. Documentation of confirmation of faxing the blood pressures monthly to the physician was lacking. Upon interview of the Administrator and QMA #1 on 10/4/13 at 2 p.m., both indicated the physician's office had no record of the blood pressures being sent to the office. The QMA indicated the physician preferred for the blood pressures to continue to be taken on non-dialysis and then faxed to his office. 5-2(e)(1)(B) 5-2(e)(1)(C)		Resident Care Director will conduct weekly MAR compliance audits. Findings and follow up will be reviewed during the monthly Quality Assurance meetings.	

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R000273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to provide safety of food storage for 1 of 1 kitchen observation in that items in dry storage were expired or opened items requiring refrigeration remained in the dry storage area. This had the potential to affect all 87 residents of the facility. Finding includes: 1. During initial dietary tour with the FSD (food service director) on 10/3/13 at 11:35 a.m., the following were observed in the dry storage area of the kitchen: a. White Vermicelli Sprinkles that had an expiration date of 1/2/13. b. Two containers of Vanilla whipped cream cheese frostings with expiration dates of 7/2013. c. Daily's Sweet and Sour liquid punch mix 64 oz. container opened with manufacture's directions to refrigerate after opening.	R000273	R273: Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.With Respect to the Specific Residents Cited: The white vermicelli sprinkles with an expiration date of 1/2/13 were removed from storage and discarded. The two containers of vanilla whipped cream cheese frosting with an expiration date of 7/20/13 were removed from storage and discarded. The Daily's Sweet and Sour liquid punch mix that was unrefrigerated after opening was removed from storage and discarded. The Nutella spread with an expiration date of 7/28/13 was removed from storage and discarded. With Respect to How the Facility will Identify Residents with the Potential for the Identified Concern and Take Corrective Action: A review of the Product Rotation, & Refrigerator Storage policy was completed by the Dining Service Director & Assistant Dining Service	11/01/2013

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	d. A container of Nutella spread, 26.5 oz , with a manufacture's expiration date of 7/28/13. On 10/3/13 at 1145 a.m. the FSD was interviewed. The FSD indicated he was was responsible for checking expiration dates. 5-5.1(f)		Director. The Dining Service Director/Designee will conduct daily random monitoring to review food expiration and storage compliance. The process for ensuring follow up and compliance checks was established.With Respect to What Systemic Measures have been put in place to Address the Stated Concern: In-service education has been scheduled for the kitchen associates to review food expiration and refrigerator storage compliance policies, procedures and expectations. With Respect to How the Plan of Corrective Measures will be Monitored: The Dining Service Director/Designee will perform random compliance follow up daily for 30 days and report findings to the Administrator weekly. Random compliance audits will then be completed and a monthly review will be made by the FSD to the administrator regarding random round compliance findings and follow up. Findings will be reviewed and follow up during the monthly QA meetings.	